SERVICES TO SEXUALLY ABUSED CHILDREN AND THEIR FAMILIES: A PRELIMINARY SURVEY

EXECUTIVE SUMMARY

THE SEXUAL ABUSE TREATMENT PROJECT

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The findings that follow summarize information obtained from program administrators and clinicians in thirty sexual abuse treatment programs located throughout the Commonwealth. The programs surveyed are all funded by the Department of Social Services (DSS) and/or by the Department of Mental Health (DMH).

- Five of the programs are affiliated with large medical hospitals.
- Fourteen are affiliated with community mental health or counseling centers.
- Four are operated by the Massachusetts Society for the for the Prevention of Cruelty to Children (MSPCC).
- Seven are operated by local offices of DSS.

From both face-to-face and telephone survey interviews, conducted between November, 1985 and February, 1986, the following were found:

- o There has been substantial growth in treatment services for sexually abused children and their families over the past six years. Accompanying this growth has been a shift from service delivery under the auspices of child abuse and neglect to specialized sexual abuse services. Most programs are now capable of offering a pluralistic approach to the problem.
- o Last year, the programs included in the survey provided sexual abuse treatment services to nearly one thousand families. Within those families services were provided to 1,100 child victims, 700 non-offending parents (mothers) and 400 male offenders.
- o The operative goals of the treatment programs are child-centered (victim focused) and reflect a combination of both therapeutic and protective priorities. Programs are consistent in their emphasis on preventing further victimization. Their services are organized to address the factors that are thought to be necessary preconditions for sexual abuse.

- The staff employed in sexual abuse treatment programs are highly trained and very experienced. They represent a variety of mental health, social service, and medical disciplines. Their skills include assessment, group therapy, family therapy, early childhood intervention, school counseling, forensic psychology, teen-age pregnancy counseling and prevention, and adult mental health services.

- Sexual abuse treatment programs are well integrated into their host organizations, but enjoy considerable autonomy with respect to everyday decision-making.

- DSS procedures for referring clients to sexual abuse treatment programs vary in complexity and may affect the timeliness of service delivery. The responses are most timely in situations where personal relationships permit informal referral practices, like telephone calls between case managers and therapists.

- Most treatment programs conduct comprehensive evaluations of the needs of sexually abused children and their families; however, programs vary in the time they allow for diagnostic activities and in the diagnostic procedures that they employ.

- Most programs have developed detailed internal quality assurance mechanisms in order to monitor standards of practice. The majority use peer or utilization review committees and follow procedures established by the Joint Committee on Accreditation of Hospitals (JCAH).

- The programs in the survey all have well-defined criteria for closing cases, which include:

  - the availability of a parent (usually the mother) who can protect the child;

  - a victim who is free of trauma-related symptomatology and who can act assertively to protect herself; and

  - an offender who is permanently out of the house, or if in the house (or returning home), has admitted responsibility for the abuse and resolved the issues that led to the abusive behavior.

- Although there are a number of factors that may mediate the effects of sexual abuse, clinicians agree that few children emerge unscathed by the experience. Among the most common symptoms reported by clinicians are:

  - a negative self-image (feeling damaged and/or different, experiencing self as bad or evil, etc.);

- difficulty in forming or sustaining relationships with others (trusting); and

- various behavioral manifestations (sexualized aggressive or compliant behaviors, physical problems, etc.).

o Treatment with child victims, as with other family members is typically multimodal, involving individual, group, dyadic, and family forms of therapy. These modalities are used to:

- communicate to the child that s/he will be believed and protected;

- help the child gain a sense of mastery and control (empowerment);

- help the child ventilate feelings of guilt, sadness, and anger;

- help the child to gradually assume age-appropriate role behaviors;

- help the child correct misconceptions and distorted thinking about abuse;

- validate feelings and fears; and

- help the child overcome her sense of being different.

o Group therapy is the preferred method of treatment for latency-aged and adolescent victims. Nearly all programs offer such services; some groups are time-limited, others long-term. Some are unstructured; others are highly organized around specific themes and activities. Most, however, are organized by age and gender.

o Therapy with non-offending parents (primarily mothers) typically consists of a mixture of traditional counseling, education, and advocacy. Most programs (80%) recognize that groups are a powerful vehicle for support and insight and routinely offer group work services. Individual and group counseling services are also aimed at consciousness-raising and increasing the mother's capacity to protect and nurture the child.

- More than half of the programs in the survey offer both individual and group therapy services to offenders. Again, group psychotherapy is the primary treatment modality; it is used in the early stages of treatment to overcome the offender's classic denial, rationalization and minimalization of the sexual offenses. New and innovative treatment methods, combining cognitive, behavioral, and psychoeducational approaches, are under consideration for future programs in a number of sites.

- Adolescent sex offender treatment services are now offered by two programs; four other programs are considering such services.

- Most programs provide family therapy only when it is clear that the family intends to reunite and only after extensive work has been completed in other modalities. More often family subsystems are targeted for intervention -- mother-daughter, sibling, and less commonly, father-daughter or marital/adult couples.

- There appear to be strong working relationships between treatment providers and DSS staff; three-quarters of the clinicians and administrators interviewed reported satisfactory or positive relationships with DSS area offices.

- Where coordination problems between clinicians and DSS social workers do exist, they appear to be related to the clinicians' perceptions that:

  - DSS social workers expect them to manage cases as well as provide clinical treatment.

  - Clinicians' recommendations regarding placement and reunification are rarely elicited for case planning.

  - DSS workers need to monitor certain cases more intensively than they sometimes do.

- There is a consensus among clinicians working in sexual abuse treatment programs that collaboration between mental health agencies and the criminal justice system is essential for reducing the fear and uncertainty that accompanies criminal justice system involvement in these cases. For example:

  - Many clinicians report that children in their caseloads suffered significant emotional distress as a direct result of court delays.

  - Clinicians also report that children get emotionally stuck during the court process, and cannot work through other abuse-related issues until some resolution is brought to the matter of the offender's culpability.

- There is also a consensus among clinicians that authority can be brought to bear on the treatment of offenders via close collaboration between courts and mental health agencies, and that this authority is essential to engaging and maintaining offenders' participation in treatment. In fact, more programs would be willing to treat offenders if alternative sentencing agreements were available in more locations (e.g., pre-trial diversion and supervisory probation).

- Although some programs have attempted to develop medical expertise by training physicians in the community, the survey results indicated that the availability of medical services for sexually abused children is a problem in many areas of the state. More than one-third of the programs surveyed indicated that there are no physicians or nurses in their communities trained to conduct physical examinations of sexually abused children or to collect physical evidence.

- During 1986, about 1200 children received specialized sexual abuse treatment services. An even greater number received other counseling services and an estimated 10% of the substantiated cases were treated by private therapists. Specialized services increased during late 1986 and 1987. The increase was directed primarily toward services for boys, children under 5 years of age, and children residing in the Southeastern part of the state, in response to the demonstrated needs and shortage of services for these populations.

- Approximately one-third of the treatment programs have some capacity to treat Spanish and/or Portuguese speakers. There have been no referrals for Asian, Haitian, or Cape Verdean immigrants.

- Nearly all programs were operating at full capacity by late 1986 and still are. One-quarter had intermittent waiting lists; two-thirds have intermittent waiting lists now. One program has a three month waiting list. This is in spite of contract expansion and due to the necessarily long-term nature of the treatment process.

- Sexual abuse treatment carries with it considerable potential for burnout among workers; families are multi-problem and resistant, and treatment is typically long term, requiring intense work. The clinical staff

in the sexual abuse treatment programs generally work 16 hours of direct client contact and 12.5 hours of collateral contacts each week. Informal support groups have been organized across the state for those who work continually in treatment services for sexual abuse.

- Program costs vary considerably due to wide-ranging unit rates and the potential of the programs to generate third-party dollars. About one-third of the programs are not eligible for third party reimbursement. About two-thirds of the clients are Medicaid-eligible or have private insurance.